AMENDED IN ASSEMBLY AUGUST 30, 2005

AMENDED IN SENATE MAY 11, 2005

AMENDED IN SENATE APRIL 28, 2005

AMENDED IN SENATE MARCH 30, 2005

SENATE BILL No. 364

Introduced by Senator Perata

February 17, 2005

An act to amend Section 1371.35 of the Health and Safety Code, relating to health care.

LEGISLATIVE COUNSEL'S DIGEST

SB 364, as amended, Perata. Health care service plans.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the regulation of health care service plans by the Department of Managed Health Care and makes a violation of the act a crime. Under existing law, a health care service plan is required to reimburse within a designated timeframe, a complete claim submitted by a provider, and this responsibility is not waived by the plan requiring its contracting entities to pay claims for covered services.

This bill would authorize a physician who has a contract with a plan *that covers services provided to an enrollee,* but not with a contracting entity of the plan, to submit a claim to the plan, and would require the plan to pay the claim pursuant to the terms of the contract between the plan and the physician. The bill would prohibit a physician ~~that has a contract with a plan from billing the patient for services covered by the plan that are not the responsibility of the patient~~ *from billing a subscriber or an enrollee in that case, except for copayments,*

deductibles, and coinsurance payments that are the responsibility of the subscriber or the enrollee.

Because the bill would specify an additional requirement for health care service plans, the violation of which would be a crime, it would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: yes.

The people of the State of California do enact as follows:

SECTION 1. The purpose of this act is to protect patients who are enrollees of health plans regulated under the Knox-Keene Health Care Service Plan Act of 1974 from being billed for emergency medical services provided by noncontracting emergency and on-call physicians. A secondary purpose of this act is to reduce the number of billing disputes between emergency and on-call physicians and health plans and their subcontractors. These purposes are accomplished by increasing the number of claims that can be paid through contracted relationships between health plans and emergency and on-call physicians.

SEC. 2. Section 1371.35 of the Health and Safety Code is amended to read:

1371.35. (a) A health care service plan, including a specialized health care service plan, shall reimburse each complete claim, or portion thereof, whether in state or out of state, as soon as practical, but no later than 30 working days after receipt of the complete claim by the health care service plan, or if the health care service plan is a health maintenance organization, 45 working days after receipt of the complete claim by the health care service plan. However, a plan may contest or deny a claim, or portion thereof, by notifying the claimant, in writing, that the claim is contested or denied, within 30 working days after receipt of the claim by the health care service plan, or if the health care

service plan is a health maintenance organization, 45 working days after receipt of the claim by the health care service plan. The notice that a claim, or portion thereof, is contested shall identify the portion of the claim that is contested, by revenue code, and the specific information needed from the provider to reconsider the claim. The notice that a claim, or portion thereof, is denied shall identify the portion of the claim that is denied, by revenue code, and the specific reasons for the denial. A plan may delay payment of an uncontested portion of a complete claim for reconsideration of a contested portion of that claim so long as the plan pays those charges specified in subdivision (b).

(b) If a complete claim, or portion thereof, that is neither contested nor denied, is not reimbursed by delivery to the claimant's address of record within the respective 30 or 45 working days after receipt, the plan shall pay the greater of fifteen dollars ($15) per year or interest at the rate of 15 percent per annum beginning with the first calendar day after the 30- or 45-working-day period. A health care service plan shall automatically include the fifteen dollars ($15) per year or interest due in the payment made to the claimant, without requiring a request therefor.

(c) For the purposes of this section, a claim, or portion thereof, is reasonably contested if the plan has not received the completed claim. A paper claim from an institutional provider shall be deemed complete upon submission of a legible emergency department report and a completed UB 92 or other format adopted by the National Uniform Billing Committee, and reasonable relevant information requested by the plan within 30 working days of receipt of the claim. An electronic claim from an institutional provider shall be deemed complete upon submission of an electronic equivalent to the UB 92 or other format adopted by the National Uniform Billing Committee, and reasonable relevant information requested by the plan within 30 working days of receipt of the claim. However, if the plan requests a copy of the emergency department report within the 30 working days after receipt of the electronic claim from the institutional provider, the plan may also request additional reasonable relevant information within 30 working days of receipt of the emergency department report, at which time the claim shall be deemed complete. A claim from a professional provider shall be deemed

complete upon submission of a completed HCFA 1500 or its electronic equivalent or other format adopted by the National Uniform Billing Committee, and reasonable relevant information requested by the plan within 30 working days of receipt of the claim. The provider shall provide the plan reasonable relevant information within 10 working days of receipt of a written request that is clear and specific regarding the information sought. If, as a result of reviewing the reasonable relevant information, the plan requires further information, the plan shall have an additional 15 working days after receipt of the reasonable relevant information to request the further information, notwithstanding any time limit to the contrary in this section, at which time the claim shall be deemed complete.

(d) This section shall not apply to claims about which there is evidence of fraud and misrepresentation, to eligibility determinations, or in instances where the plan has not been granted reasonable access to information under the provider's control. A plan shall specify, in a written notice sent to the provider within the respective 30 or 45 working days of receipt of the claim, which, if any, of these exceptions applies to a claim.

(e) If a claim or portion thereof is contested on the basis that the plan has not received information reasonably necessary to determine payer liability for the claim or portion thereof, then the plan shall have 30 working days or, if the health care service plan is a health maintenance organization, 45 working days after receipt of this additional information to complete reconsideration of the claim. If a claim, or portion thereof, undergoing reconsideration is not reimbursed by delivery to the claimant's address of record within the respective 30 or 45 working days after receipt of the additional information, the plan shall pay the greater of fifteen dollars ($15) per year or interest at the rate of 15 percent per annum beginning with the first calendar day after the 30- or 45-working-day period. A health care service plan shall automatically include the fifteen dollars ($15) per year or interest due in the payment made to the claimant, without requiring a request therefor.

(f) (1) The obligation of the plan to comply with this section shall not be deemed to be waived when the plan requires its medical groups, independent practice associations, or other contracting entities to pay claims for covered services. This

section shall not be construed to prevent a plan from assigning, by a written contract, the responsibility to pay interest and late charges pursuant to this section to medical groups, independent practice associations, or other entities.

(2) ~~If a physician has a contract with a plan~~ *If a physician provides services to an enrollee of a plan and the physician has a contract with the plan that covers the services provided to that enrollee,* but does not have a contract with a medical group, independent practice association, or other entity that has ~~been required by the plan~~ *agreed by contract with the plan* to pay claims for covered services *for that enrollee*, the physician may submit a claim to the plan for services covered by the plan and provided to the enrollee of the plan~~, and the plan,~~. *In this case, the plan,* and not the medical group, independent practice association, or other entity, shall pay the physician the claim pursuant to the terms of the contract between the plan and the physician~~. A physician who has a contract with a plan shall not bill the patient for services covered by the plan, except for copayments, deductibles, and coinsurance payments that are the responsibility of the patient~~*., and the physician shall not bill the subscriber or the enrollee for these services. However, nothing in this paragraph precludes a physician from billing a subscriber or an enrollee for copayments, deductibles, and coinsurance payments that are the responsibility of the subscriber or the enrollee. Nothing in this paragraph affects the provisions of Section 1379.*

(g) A plan shall not delay payment on a claim from a physician or other provider to await the submission of a claim from a hospital or other provider without citing specific rationale as to why the delay was necessary and providing a monthly update regarding the status of the claim and the plan's actions to resolve the claim, to the provider that submitted the claim.

(h) A health care service plan shall not request or require that a provider waive its rights pursuant to this section.

(i) This section shall not apply to capitated payments.

(j) This section shall apply only to claims for services rendered to a patient who was provided emergency services and care as defined in Section 1317.1 in the United States on or after September 1, 1999.

(k) This section shall not be construed to affect the rights or obligations of any person pursuant to Section 1371.

(*l*) This section shall not be construed to affect a written agreement, if any, of a provider to submit bills within a specified time period.

SEC. 3. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

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